Weisman

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-04

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECEIVED MAR 31 2003

4. PROPOSED EFFECTIVE DATE
January 1, 2003

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-.252 and 42 CFR 447.256-.299

7. FEDERAL BUDGET IMPACT:

a. FFY	2003	$0
b. FFY	2004	$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, page 5
Attachment 4.19-B, pages 5a, 5b (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*):
Attachment 4.19-B, page 5

Alaska (03-04)
Approved: 12/17/03
Effective: 01/01/03

10. SUBJECT OF AMENDMENT:
Outpatient Hospital Services

11. GOVERNOR'S REVIEW (*Check One*):
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. [signature]

13. TYPED NAME: Virginia Stonkus

14. TITLE: Acting Director, Division of Medical Assistance

15. DATE SUBMITTED: March 27, 2003

16. RETURN TO:
Division of Medical Assistance
PO Box 110660
Juneau, AK 99811-0660

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: MAR 31 2003

18. DATE APPROVED: DEC 17 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Karen S. O'Connor

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health

23. REMARKS: Pen & Ink (P&I) changes authorized by the State

POSTMARKED: 3/27 (DATE) Juneau (CITY/STATE)

FORM HCFA-179 (07-92)

Methods and Standards for Establishing Payment Rates: Other Types of Care

Nutrition Services

Payment to a registered dietitian is limited to the lesser of the amount billed the general public or a maximum of $50 for an initial assessment, counseling, or evaluation; and $35 for each subsequent visit.

Outpatient Hospital Services

Rate setting principles and methods for Outpatient Hospital Services are contained in Alaska Statutes 47.07.070 - 47.07.900 and administrative regulations in Alaska Administrative Code 7 AAC 43. The Department of Health and Social Services uses the following data sources for setting rates of payment:

- For facilities whose fiscal years begin January 1, 2001 through December 31, 2001, the department will use the as filed reports from the facility's fiscal year ending during calendar year 1999 and the department generated MR-0-14 report which includes claims data processed no later than September 26, 2000.

- When rebasing occurs, the Medicare Cost Report for the facility's fiscal year ending 24 months before the beginning of the year that is rebased.

- Budgeted capital costs, submitted by the facility and reviewed and adjusted by the Department as appropriate for the rate year on capital projects or acquisitions which are placed in service after the base year and before the end of the rate year and for which an approved Certificate of Need has been obtained.

- Year-end reports that contain historical financial and statistical information submitted by facilities for past rate setting years.

- Utilization and payment history report (commonly known as the MR-0-14) provided by the Division of Medical Assistance.

Allowable costs are documented costs that are ordinary and necessary in the delivery of a cost effective service. Allowable costs are those which directly relate to Title XIX program recipients. Costs would include those necessary to conform to state and federal laws, regulations, and quality and safety standards.

Most of the elements of Medicaid allowable costs are defined in Medicare and reported, subject to audit, on the Medicare Cost Report. The following items are possible adjustments from financial statement classifications to Medicaid classifications, and may be reflected either within the Medicare Cost Report or elsewhere in the Medicaid cost finding process.

* return on investment is not an allowable cost for any facility.

* advertising cost is allowable only to the extent that the advertising is directly related to patient care. The reasonable cost of only the following types of advertising and marketing is allowable:
  - announcing the opening of or change of name of a facility.
  - recruiting for personnel.
  - advertising for the procurement or sale of items.
  - obtaining bids for construction or renovation.
  - advertising for a bond issue.
  - informational listing of the provider in a telephone directory.
  - listing a facility's hours of operation.
  - advertising specifically required as a part of a facility's accreditation process.

* physician compensation costs and related charges associated with providing care to patients are not allowable for purposes of calculating a prospective payment rate.

* medical services which a facility or unit of a facility is not licensed to provide are not included as an allowable cost.

* costs not authorized by a certificate of need when a certificate of need is required are not included as an allowable cost.

Allowable patient related costs include wages, salaries, and employee benefits, purchased services; supplies; utilities, depreciation, rentals, leases; taxes, excluding local, state and federal income taxes; and interest expense. A facility must reduce operating costs by the cost of all activities not directly related to health care. Other specific non-allowed costs are bad debts, charity, contractual adjustments and discounts taken by payers. Certificate of need capital is not included in the percentage of charges rate for outpatient hospital services.

Prospective payment rates for outpatient hospital services are a percentage of charges except outpatient clinical laboratory services. Except as stated in this Subsection, the prospective payment rate for outpatient clinical laboratory services will be a per-procedure rate based on reasonable costs as determined by the Medicare fee schedule.

The prospective percentage of charges payment rate for acute hospital outpatient services is determined by applying the outpatient cost to charge ratio for each outpatient cost center from the Medicare Cost Report to the cost center's Medicaid outpatient charges. Laboratory is not included in the cost centers. The sum of the Medicaid outpatient costs for all outpatient cost centers will then be divided by total Medicaid outpatient charges. The resulting cost to charge percentage, not to exceed 100 percent, will be the prospective outpatient payment rate effective for the fiscal year. Facilities choosing reimbursement under the Optional Prospective Payment Rate Methodology for Small Facilities described in Attachment 4.19A will have their outpatient clinical laboratory services reimbursed at their prospective outpatient percentage of charges payment rate for the term of their agreement.

If a facility reports zero Medicaid charges in the outpatient clinic cost center of the Medicare cost report, the total hospital costs reported in that cost center are multiplied by the quotient of the total Medicaid outpatient hospital charges divided by the total hospital outpatient charges to calculate a cost that is included in the overall outpatient calculation. Payment rates are based on 1999 fiscal year data. After this initial rate year, rebasing will occur for all facilities no less than every four years.

A small acute care hospital facility is defined as one that had 4,000 or fewer total inpatient hospital days as a combined hospital-nursing facility or 15,000 or fewer Medicaid nursing days as a non-combined nursing facility during the facility's fiscal year that ended 24 months before the beginning of its prospective payment rate year beginning during calendar year 2003. Such a facility may elect a new four-year rate agreement if the facility becomes a combined acute care hospital-nursing facility. The facility may choose this option within 30 days after the two facilities combine. The outpatient percentage rate is calculated as the statewide average of the outpatient payment rates in effect for all qualified acute care hospital small facilities as of the date the facilities combine.

For a new facility, the outpatient prospective payment rate percentage is established at the statewide weighted average outpatient payment percentages of acute care and specialty hospitals, in accordance with this section, for the most recent 12 months of permanent rates. To determine this weighted average, Medicaid charges for the most recent 12 months from each facility are multiplied by the facility's respective rate to get the payment. The sum of facilities' payments is then divided by the sum of their charges to calculate a weighted average outpatient payment percentage.

Personal Care Services

Services are reimbursed at the lesser of the amount billed the general public or the state maximum allowable.

Physical and Occupational Therapy Services

Payment is made at the lesser of billed charges, 85 percent of the Resource Based Relative Value Scale methodology used for physicians, the provider's lowest charge, or the maximum allowable for procedures that do not have an established RVU.